NON-PUBLIC?: N
ACCESSION #: 8712220126
LICENSEE EVENT REPORT (LER)

FACILITY NAME: Plant Vogtle - Unit 1 PAGE: 1 of 4

DOCKET NUMBER: 05000424

TITLE: Inadequate Labeling Causes A Personnel Error Which Causes A Reactor Trip
EVENT DATE: 11/11/87 LER #: 87-066-00 REPORT DATE: 12/10/87

OPERATING MODE: 1 POWER LEVEL: 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR SECTION
50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER:
NAME: W. E. Burns, Nuclear Licensing Manager - Vogtle
TELEPHONE #: 404-526-7014

SUPPLEMENTAL REPORT EXPECTED: No

ABSTRACT: On November 11, 1987, at 0344 CST with Unit 1 in Mode 1 (power operation) at 100 percent rated thermal power, an unplanned actuation of the Reactor Protection System occurred. Plant personnel were conducting a surveillance test of the Train "A" reactor trip breakers as required by the unit's technical specifications. As part of this test, the Train "A" reactor trip breakers had been opened. A Shift Technical Advisor (STA) depressed a shunt trip test pushbutton on the opposite train (Train "B") trip breaker panel cabinet and a reactor trip occurred. The Train "B" motor driven auxiliary feedwater (MDAFW) pump automatically started. The Train "A" MDAFW pump was manually started because its automatic initiation circuit was blocked as part of the reactor trip breakers surveillance testing. The turbine driven AFW pump automatically started on low-low steam generator water level. Operators stabilized plant conditions in Mode 3 following the reactor trip.

This event was caused by personnel error, in that an STA opened the wrong trip breaker cabinet and pushed the opposite train's shunt trip test pushbutton. Corrective action includes better labeling of each cabinet, revising the surveillance procedure to include specific panel and pushbutton numbers, and positive discipline of appropriate individuals.

(End of Abstract)

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(iv) because an unplanned actuation of the Reactor Protection System (RPS) occurred.

B. UNIT STATUS AT TIME OF EVENT

Unit 1 was in Mode 1 (power operation) at 100 percent rated thermal power. Surveillance testing of the reactor trip breakers was ongoing at the time of the event. The automatic actuation circuit of the Train "A" motor driven auxiliary feedwater pump was blocked as part of the surveillance testing of the Train "A" reactor trip breakers. There was no other inoperable equipment that contributed to this event.

C. DESCRIPTION OF EVENT

On November 11, 1987, plant personnel were conducting a Technical Specifications (T.S.) surveillance test (Table 4.3-1) of the Train "A" reactor trip breakers per procedure 14701-1, "Reactor Trip Breakers Undervoltage and Shunt Trip Test". A Shift Technical Advisor (STA) (utility) closed the Train "A" bypass breakers and moved to the rear of the panel to perform the shunt trip test. The Train "A" test panel and Train "B" test panel are located in adjoining cabinets which were not clearly marked (on the rear of the panels) as belonging to either Train "A" or Train "B". The STA inadvertently opened the Train "B" cabinet (which allowed access to the Train "B" test panel) and depressed the shunt trip test pushbutton. Actuating the Train "B" shunt trip correctly resulted in the opening of the Train "A" bypass breaker and the Train "B" reactor trip breaker. The resulting reactor trip occurred at 0344 CST.

The Train "A" reactor trip breaker was opened manually, per operations procedures, from the control room. The main feedwater system isolated, as expected, and the auxiliary feedwater system actuated i.e., the Train "B" pump automatically started. The Train "A" MDAFW pump did not automatically actuate because its circuitry was blocked because of the reactor trip breaker surveillance testing ongoing at the time. The Train "A" pump was started manually. Upon reaching the steam generator low-low level setpoint, the turbine driven AFW (TDAFW) pump automatically

started. Control room operators, following the trip, stabilized the plant in Mode 3 (hot standby).

D. CAUSE OF EVENT

The immediate cause of this event is the personnel error on the part of the STA who entered the incorrect trip breaker test panel cabinet. The root cause of this event is inadequate labeling of the trip breaker cabinets. Contributing to the inadequate labeling are the following.

1) Cabinet tag numbers not identified in the surveillance test procedure.

2) This was the first time that the employee had performed this surveillance and his training had not specifically addressed train-related details.

E. ANALYSIS OF EVENT

The reactor trip breakers are designed to protect the plant. One train of the reactor trip breakers can be placed in bypass for testing, but any attempt to test the other train at the same time or the receipt of a valid signal will automatically open the bypass and trip the breaker, causing a reactor trip. The breakers correctly performed their intended design function. The Train "A" MDAFW pump did not automatically start due to its circuitry being blocked due to the reactor trip breaker surveillance testing; however, operators responded correctly by manually starting the pump. The other auxiliary feedwater pumps (MDAFW pump "B" and the TDAFW pump) started as required. Based on these considerations, this event had no adverse affect on either plant safety or public health and safety.

F. CORRECTIVE ACTIONS

1. Procedure 14701-1 has been changed to identify specific panel and pushbutton numbers. The procedure also has been revised to provide instructions for using Maintenance and Test Equipment during the performance of the surveillance test to confirm the correct train prior to testing the reactor trip breakers.

2. Labels have been placed on the reactor trip breaker panels to assist identification.

3. An event summary was placed in the shift briefing book.

4. Training will be conducted to ensure all personnel performing surveillance testing on the RPS or Engineered Safety Feature systems can properly address the train-related details of the surveillance testing.

5. Positive discipline was administered to appropriate individuals.

G. ADDITIONAL INFORMATION

1. Failed Components
None

2. Previous Similar Events
None

3. Energy Industry Identification System

Auxiliary Feedwater System - BA
Reactor Protection System - JD
Main Feedwater System - SJ

Georgia Power Company
333 Piedmont Avenue
Atlanta, Georgia 30308
Telephone 404 526-6526

Mailing Address:
Post Office Box 4545
Atlanta, Georgia 30302

Georgia Power

L. T. Gucwa the southern electric system
Manager Nuclear Safety
and Licensing

SL-3813

0660m
X7GJ17-V310

December 10, 1987

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

PLANT VOGTLE - UNIT 1
NRC DOCKET 50-424
OPERATING LICENSE NPF-68
LICENSEE EVENT REPORT
INADEQUATE LABELING CAUSES A PERSONNEL
ERROR WHICH CAUSES A REACTOR TRIP

Gentlemen:

In accordance with the requirements of 10 CFR 50.73(a)(2)(iv), Georgia Power Company is submitting a Licensee Event Report (LER) concerning a reactor trip.

Sincerely,

/s/ L T Gucwa
L. T. Gucwa

PAH/lm

Enclosure: LER 50-424/1987-066

c: (see next page)

ATTACHMENT # 1 TO ANO # 8712220126 PAGE: 2 of 2

Georgia Power

U. S. Nuclear Regulatory Commission
December 10, 1987
Page Two

c: Georgia Power Company
Mr. J. P. O'Reilly
Mr. P. D. Rice
Mr. G. Bockhold, Jr.
Mr. J. E. Swartzwelder

Mr. C. W. Hayes
GO-NORMS

Southern Company Services
Mr. R. A. Thomas
Mr. J. A. Bailey

Shaw, Pittman, Potts & Trowbridge
Mr. B. W. Churchill, Attorney-at-Law

Troutman, Sanders, Lockerman & Ashmore
Mr. A. H. Domby, Attorney-at-Law

U. S. Nuclear Regulatory Commission
Dr. J. N. Grace, Regional Administrator
Mr. J. B. Hopkins, Licensing Project Manager, NRR (2 copies)
Mr. J. F. Rogge, Senior Resident Inspector-Operations, Vogtle

0660m

*** END OF DOCUMENT ***